DCH/LDN-509 (07/04)

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

DENTAL ASSISTANT ENDORSEMENT INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Dentistry. Questions regarding your application can be directed to the Michigan Board of Dentistry at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

GENERAL INSTRUCTIONS

1. The Michigan Board of Dentistry may issue a registration by endorsement to an applicant who is currently licensed/registered in another state if that state's licensure/registration requirements are substantially equivalent to those required in Michigan.

2. Read all instructions carefully and answer all questions on the application including providing details on a separate sheet if necessary. Failure to correctly complete the application in its entirety may delay the processing of your application. You must provide a complete listing of **all states** (excluding temporary licensed/registrations) in which you have **ever** held a dental assistant licensed/registration.

3. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

4. You are required by law to notify this office within 30 days if:

   a. **YOU CHANGE YOUR NAME** - Send a letter advising us of the name change. Please be sure to include your license/registration number and the name under which you are currently licensed/registered as well as your new name. This information can be faxed to (517) 373-2179.

   b. **YOU CHANGE YOUR ADDRESS** - Send correct address information including street number, street name, apartment number, P.O. Box or R.D. number, city, state and ZIP Code. Be sure to include your license/registration number in the correspondence. This information can be faxed to (517) 373-2179.

5. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Dentistry in writing to request a refund.

REGISTRATION BY ENDORSEMENT INSTRUCTIONS

1. Complete the application for registration in its entirety and submit it with the required fee. Applications submitted without the registration fee will be returned.

2. You must complete **PART I** of the enclosed Endorsement Certification form and mail it to the state in which you were originally licensed/registered by examination for completion of **PART II** by that state. **Contact your original state of licensure for information regarding fees charged for this service.**

3. In addition to the Endorsement form from your original state of licensure, a Verification of Licensure form must be forwarded to this office **from** EACH additional state in which you hold or have ever held a dental license/registration. The Verification of Licensure form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.

4. Submit a FINAL, OFFICIAL transcript of grades from your dental assistant program. **The transcript must be submitted directly to this office from your school.**

5. If you have taken another state examination, please arrange to have that state's testing agency forward a copy of the examination specifications and your scores to the Michigan Board of Dentistry. The examination you took will be evaluated by the Michigan Board to see if it is equivalent to the Michigan RDA examination. You will be notified by the Board's decision to accept either the examination you took or require that you pass all or part of the Michigan RDA examination.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Dentistry in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Dentistry in writing to request a refund.

ORIGINAL REGISTRATIONS ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

DCH/LDN-031 (07/04)

APPLICATION FOR REGISTRATION BY ENDORSEMENT

Authority: Public Act 368 of 1978, as amended
if this form is not completed, a license will not be issued.

Type or Print Only

Board Use Only
License Number
Date of Licensure

I AM APPLYING FOR THE FOLLOWING:

☐ **Dental Assistant Registration by Endorsement Fee: $30.00 71-2901-09**

Your check or money order drawn on a U.S. Financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Telephone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		

Have you ever held a health professional license in Michigan?

☐ No ☐ If yes, list Michigan permanent I.D./license number and expiration date: _____

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ Yes	☐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	☐ Yes	☐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☐ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No
7. Have you ever had a federal or state health professional license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	☐ No
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	☐ Yes	☐ No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

9. Do you hold or have you ever held a license for your profession (other than an educational, temporary or limited license) in any state? If yes, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). **You must have each state board** verify **licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License Number	Date of Issue	How obtained (Endorsement or examination)

10. Have you previously applied for licensure to the Michigan Board? ☐ Yes ☐ No

11. Name the state from which you are endorsing: _____

12. What examination did you take to obtain licensure?

REGIONAL BOARD: (If NERB, list date of exam) _____

STATE CONSTRUCTED: List state and date of exam _____

Provide complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and Address of Institution	Dates of Attendance From	To	Degree

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Dentistry
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

ENDORSEMENT CERTIFICATION

Authority: Public Act 368 of 1978, as amended
if this form is not completed, a license will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the state licensing agency for completion of Section II. This certification must be submitted directly to the Michigan Board of Dentistry by the state licensing agency where you were originally licensed.

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Street Address		
City		
State		ZIP Code
Daytime Phone Number	All Previous Names and/or Birth Name Used (if applicable)	

Professional School Attended
Street Address
City
State
ZIP Code

Signature of Applicant	Date

Applicant: Upon completion of Section I, send to the licensing agency in the state from which you are endorsing for completion of Section II on Page 2 of this form.

Name

THIS SIDE TO BE COMPLETED BY THE LICENSING AGENCY IN THE STATE FROM WHICH THE APPLICANT IS ENDORSING

SECTION II - CERTIFICATION OF LICENSE INFORMATION

Please complete the following noting any exceptions to the information requested. Return this completed certification directly to the Michigan Board of Dentistry at the address shown on the reverse side of this form.

Applicant's Name as Licensed	
License Number	Date Issued
License Status	Expiration Date

1. Has the applicant incurred any disciplinary proceedings in your state? (Please attach certified copies of any actions.) ☐ Yes ☐ No
2. Are disciplinary proceedings pending? ☐ Yes ☐ No
3. Has the applicant's license ever been limited, denied, surrendered, suspended or revoked? (Please attach certified copies of any actions.) ☐ Yes ☐ No

EXAMINATION INFORMATION

Licensure requirements in effect at the time applicant was licensed in your state:

☐ Degree

☐ Accredited School

☐ National Board Exams

☐ Licensure Exam - Please Specify ☐ Regional ☐ State Constructed

☐ Other: Please Specify _____

Dates of Examination

Name

WRITTEN/COMPREHENSIVE EXAMINATION

EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE	EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE

CLINICAL EXERCISES EXAMINATION

EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE	EXAMINATION SUBJECT	TOTAL POSSIBLE POINTS	APPLICANT'S SCORE

What was the passing score that was in effect at the time the above examination was taken?

Please describe the criteria used to determine the passing level:

Authorized Signature

Date of Signature

Print or Type Name and Title

State Board

(S E A L)

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.